MARYLAND MEDICAID

UB-92 HOSPITAL

BILLING INSTRUCTIONS

January, 2004

(Rev. 6/05)

COMPLETION OF UB-92 FOR HOSPITAL INPATIENT/OUTPATIENT SERVICES

The UB-92 is a uniform institutional provider bill suitable for use in billing multiple third party payers.

These instructions detail only those data elements, which are required for Medical Assistance (MA) billing. When billing multiple third parties, complete all items required by each payer who is to receive a copy of the form.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted.

Effective January 1, 2004 – June 30, 2005, Hospital Day Limits will be applied to admissions for patients 21 years of age or older. The Department will reimburse hospital providers for all medically necessary days up to the day limit, which have been approved by the Department's utilization control agent. Medically unnecessary days or days denied for technical reasons, such as failure to comply with the Department's concurrent review process, *will not be reimbursed* by the Department. Unlike days below the day limit that are determined to be medically unnecessary, technical denials *will count towards* the allowable number of hospital days under the Department's established day limits.

Please refer to Attachment A for a listing of all Maryland and DC hospitals subject to Day Limits. Please refer to Attachment B to review the Maryland Medicaid Acute Hospital Review Procedures and Non-Psychiatric Acute Care Examples. For more information regarding Hospital Day Limits, please refer to Hospital Transmittal #187, Fee-for-Service Hospital Day Limits, which can be found on our website: www.dhmh.state.md.us/medcareprog; click on Medicaid Provider Transmittals.

Invoices for inpatient and outpatient services must be received within nine (9) months of the date of discharge. Invoices for chronic, psych., rehab., mental and RTC facility hospital services must be received within 9 months of the month of service on the invoice. If a claim is received within the 9 month limit but rejected, resubmission will be accepted within 60 days of the date of rejection or within 9 months of the date of discharge (or month of service if chronic), whichever is longer. If a claim is rejected because of late receipt, the patient may not be billed for that claim. If a claim is submitted and neither a payment nor a rejection is received within 90 days, the claim should be resubmitted.

Specialty Mental Health claims must be submitted to APS at the following address: MAPS-MD, P.O. Box 7061 Silver Spring, MD 20907-7061. They may also be reached by contacting 1-800-888-1965.

For any claim initially submitted to Medicare and for which services have been approved or denied, requests for reimbursement shall be submitted and received by the Program within 9 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.

All third-party resources, such as insurance or Worker's Compensation, should be billed first and payment either received or denied before the Medical Assistance Program may be billed for any portion not covered. However, if necessary to meet the 9 month deadline for receipt of the claim(s), the Medical Assistance Program may be billed first and then reimbursed if the third-party payer makes payment later.

Invoices may be typed or printed. If printed, the entries must be legible. Do not use pencil or a red pen to complete the invoice. Otherwise, payment may be delayed or the claim rejected.

Completed invoices are to be mailed to the following address:

Maryland Medical Assistance Program
Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203

The instructions, which follow, are keyed to the form locator number and headings on the UB-92 form.

FL 1 **(Untitled)**

Provider name, address, zip code, and telephone number.

Line 1 -- Enter the provider name filed with the Medical Assistance Program.

Line 2 & 3 -- Enter the address to which the invoice should be returned if it is rejected due to provider error.

NOTE: Checks and remittance advices are sent to the provider's address as it appears in the Program's provider master file.

Line 4 -- Enter provider area code and phone number (optional).

FL 2 **(Untitled)**

DO NOT USE. This field has been assigned by Maryland Medicaid for internal use only. (ICN- Invoice Control Number)

FL 3 **Patient Control Number (Mandatory)**

Enter the patient's control number assigned to the patient by the hospital. A maximum of 11 positions will be returned on the remittance advice to the provider. The hospital must assign each patient a unique number.

FL 4 **Type of Bill**

This three-digit numeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third digit indicates the bill sequence for this particular episode of care and is referred to as a "frequency" code. All three digits are required to process a claim.

CODE STRUCTURE	**(Only codes used to bill MA are shown)**
Type of Facility	(1st digit)
Bill Classification	(2nd digit)
Frequency	(3rd digit)

Type of Facility	**1st Digit**
Hospital	1
Special (Hospice)	8

Bill Classification	**2nd Digit**
Inpatient	1
Hospice (non-hospital based)	1
Hospice (hospital based)	2
Outpatient	3
Chronic	5
Mental (Psych., Residential Trt. Ctr.)	6

Frequency	**3rd Digit**
Non-Payment/Zero Claim (NOT USED)	0
Admit Through Discharge Claims	1
Interim Billing - First Claim	2
Interim Billing- Continuing Claim	3
Interim Billing - Last Claim	4
Late Charge(s) Only Claim	5
Adjustment of Prior Claim (NOT USED)	6
Replacement of Prior Claim (Future)	7
Void/Cancel of Prior Claim (Future)	8

Frequency codes "7" and "8" will be available in the future. Do not use them until notified of their availability. Use of these codes currently will result in rejection of your invoice.

DEFINITIONS FOR FREQUENCY

(0) - Non-Payment/Zero Claim (NOT USED)

This code is to be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill; but needs to inform the payer of the non-reimbursable periods of confinement or termination of care.

(1) - Admit Through Discharge Claims

This code is to be used when a bill is expected to be the only bill to be received for a course of treatment of inpatient confinement. This will include bills representing a total confinement or course of treatment, and bills, which represent an entire benefit period of the primary third party payer. Complete locators 6, 17 and use code 42 in locators 32a - 35b.

(2) - Interim Billing - First Claim (To be used with Bill Classification 1, 5 and 6 **ONLY**)

This code is to be used for the first of a series of bills to the same third party payer for the same confinement or course of treatment. Complete locators 6 and 17. Locator 22 should equal "30".

(3) - Interim - Continuing Claim (To be used with Bill Classification 1, 5 and 6 **ONLY**)

This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted. Complete locators 6 and 17. Location 22 should equal "30".

(4) - Interim - Last Claim (To be used with Bill Classification 1, 5 and 6 **ONLY**)

This code is to be used for the last of a series of bills for which payment is expected to the same third party payer for the same confinement or course of treatment. Complete locator 6 and use code 42 in locators 32a - 32b.

(5) - Late Charge(s) Only

This code is to be used for submitting additional charges to the payer which were identified by the provider after the admit through discharge or the last interim claim has been submitted. This code is not intended for use in lieu of an adjustment claim or a replacement claim.

1. FL 6 "Statement Covers Period" on the late charge claim must be the same as the dates of the original claim to which the last charge refers. In addition, all "general information" must be the same on the late charge claim and the original claim.

2. FL 7 "Covered Days" must remain blank.

3. Late charges are subject to the 9 month statute of limitations.

4. Late charges will be allowed one time only for each patient bill with which the late charges are associated.

5. Late charge invoices must be accompanied by a copy of the original invoice, the remittance advice number, and the date on which the original invoice was paid. This information should be clearly noted on the copy of the original bill.

(6) Adjustment of Prior Claim (NOT USED)

Adjustments should be completed when a specific bill has been issued for a specific provider, patient, payer, insured and "statement covers period" date(s); the bill has been paid; and the supplemental payment is needed. To submit an adjustment, a provider should complete a DHMH-4518A, Adjustment Form and mail that form to the address below:

Maryland Medical Assistance Program
Adjustment Section
P.O. Box 13045
Baltimore, MD 21203

(7) - Replacement of Prior Claim (FUTURE)

This code is to be used when a specific bill has been issued for a specific provider, patient, payer, insured and "statement covers period" and it needs to be restated in its entirety, except for the name identity information. In using this code, the payer is to operate on the principal that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill. This code is not intended to be used in lieu of a Late Charge(s) Only claim.

(8) - Void/Cancel of Prior Claim (FUTURE)

This code reflects the elimination in its entirety of a previously submitted bill for a specific provider, patient, insured and "statement covers period" dates. The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.

*Frequency Codes "7" and "8" will be available in the future. Do not use until notified of their availability. Use of these codes currently will result in rejection of your invoice.

FL 5 **Federal Tax No.**

Not required.

FL 6 **Statement Covers Period (From - Through)**

This field is to be used for inpatient billing only. **Do not complete this field for outpatient billing.**

Enter the "From" and "Through" dates covered by the services on the invoice (MMDDYY). The "Through" date equals the date through which we are paying for accommodations. Remember that Medical Assistance does not pay for accommodations for the date of death/discharge. The date of death/discharge should never be shown as the through date in this field.

NOTE A: For all services received on a single day both the "From" and "Through" dates will be the same. (Inpatient Only)

NOTE B: "Split" billing. An acute care hospital may not "split" a Medical Assistance bill except for the conditions listed below. All charges for any admission must be included on a single invoice. The exceptions are:

1. A gap has occurred in Medical Assistance eligibility.

2. The DHMH 3808, Admission and Length of Stay Certification, shows multiple approval and denial date ranges during the same inpatient stay.

3. Family planning and sterilization charges and services must be separated from non-sterilization charges and services. (Vaginal deliveries only).

4. Abortion charges and services must be separated from non-abortion charges and services.

5. Medicare coinsurance and deductible amounts must be billed separately from non-Medicare covered regular charges.

6. Administrative Days must be billed separately from acute hospital days and must have the DHMH 1288, Report of Administrative Days form attached.

NOTE C: Medicare Part A and Part B claims should include the from and thru dates as indicated on the Medicare payment listing or EOMB.

FL 7 **Covered Days**

Enter the number of days of accommodations covered by the Medical Assistance Program.

FL 8 **Non-covered Days**

Required for day limit uncompensated care billing. Enter the number of days of accommodations not covered by the Medical Assistance Program

FL 9 **Co-insurance Days**

Required when Medicare is identified as any one of the payers in FL50 A, B or C.

Enter the inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness.

FL 10 **Lifetime Reserve Days**

Required when Medicare is identified as any one of the payers in FL 50 A, B or C.

Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness. Enter the lifetime reserve days the patient has elected to use.

FL 11 **Untitled**

Optional. Enter the 3-digit DRG, if applicable.

FL 12 **Patient Name**

Enter the patient's name as it appears on the Medical Assistance card: last name, first name, and middle initial. (Please print this information clearly.)

If you are billing for a newborn, you must use the newborn's full name.

FL 13 **Patient Address**

Enter the patient's address (desired by not required).

FL 14 **Patient Birth Date**

Enter the month, day, and year of birth (mmddyyyy). Example: 05012000.

FL 15 **Patient Sex**

Enter - M – Male F – Female U - Unknown

FL 16 **Patient Marital Status**

Not required.

FL 17 **Admission/Start of Care Date**

Enter the date of admission for inpatient services. Chronic, psych, mental, rehab and RTC facilities enter the date of admission for the first month of billing only.

Enter the date of service for an outpatient claim.

* Only one date of service for outpatient charges may be billed on a single UB-92. (Continuing treatment must be billed on a day-to-day basis).

FL 18 **Admission Hour (Mandatory)**

Enter the code for the hour during which the patient was admitted for inpatient care from the following table:

CODE STRUCTURE:

Code	Time	Code	Time
00	12:00-12:59 Midnight	12	12:00-12:59
01	01:00-01:59	13	01:00-01:59
02	02:00-02:59	14	02:00-02:59
03	03:00-03:59	15	03:00-03:59
04	04:00-04:59	16	04:00-04:59
05	05:00-05:59	17	05:00-05:59
06	06:00-06:59	18	06:00-06:59
07	07:00-07:59	19	07:00-07:59
08	08:00-08:59	20	08:00-08:59
09	09:00-09:59	21	09:00-09:59
10	10:00-10:59	22	10:00-10:59
11	11:00-11:59	23	11:00-11:59

FL 19 **Type of Admission**

This field is to be used for inpatient billing only. Enter code indicating priority of this admission.

Code Structure:

1 - Emergency	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
2 - Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
3 - Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4 - Newborn	Use of this code necessitates the use of a special Source of Admission code - see Form Locator 20.
5 – Trauma Center	Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

FL 20 **Source of Admission**

Required for Inpatient. Optional for Outpatient.

NOTE: Newborn coding structure must be used when the Type of Admission Code in Form Locator 19 is code 4.

Code Structure (for Emergency, Elective or Other Type of Admission):

1 - Physician Referral
2 - Clinic Referral
3 - HMO Referral
4 - Transfer from a hospital
5 - Transfer from a skilled nursing facility
6 - Transfer from another health care facility (other than an acute care or skilled nursing facility)
7 - Emergency Room
8 - Court/Law Enforcement

Code Structure (for Newborn):

1 -	Normal Delivery	A baby delivered without complications
2 -	Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
3 -	Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
4 -	Extramural Birth	A newborn born in a non-sterile environment.

FL 21 **Discharge Hour**

Not required.

FL 22 **Patient Status**

Enter code from code structure below indicating the patient's disposition at the time of billing for that period of inpatient care.

Code Structure:

01 - Discharged to self or home care (routine discharge)

02 - Discharged/transferred to another short term general hospital for inpatient care.

03 - Discharged/transferred to skilled nursing facility (SNF).

04 - Discharged/transferred to an intermediate care facility (ICF)

05 - Discharged/transferred to another institution for inpatient care or referred for outpatient services to another institution

06 - Discharged/transferred to home under care of organized home health service organization.

07 - Left against medical advice or discontinued care.

20 - Expired

30 - Still a patient

FL 23 **Medical Record Number**

Enter the medical record number assigned to the patient by the hospital. Up to 13 positions may be entered. The medical record number is a mandatory entry.

FL 24-30 **Condition Codes**

Enter the corresponding code to describe any of the following conditions that apply to this billing period.

Code Structure:

INSURANCE CODES

01	Military Service Related	Medical condition occurring during military service.
02	Employment Related	Patient alleges that medical condition is due to environment/events resulting from employment.
03	Patient Covered by Insurance not Reflected	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.

04	HMO Enrollee	Indicates beneficiary is enrolled in a Health Maintenance Organization (HMO).
05	Lien Has Been Filed	Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.

ACCOMODATIONS

39	Private Room Medically Necessary	Patient needs a private room for medical requirements. Give justification on the 3808.
40	Same Day Transfer	Patient transferred to another facility before midnight on the day of admission.

RENAL DIALYSIS SETTING

71	Full Care in Unit	Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit	Code indicates the billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	Code indicates the billing is for special dialysis services where a patient and his helper (if necessary) were learning to perform dialysis.
74	Home	Code indicates the billing is for a patient who received dialysis services at home, but where code 75 below does not apply.
75	Home - 100% Reimbursement	Code indicates the billing is for a patient who received dialysis services at home, using a dialysis machine that was purchased by Medicare under 100 percent program.

SPECIAL PROGRAM INDICATOR CODES

A1	EPSDT/CHAP	Early and Periodic Screening Diagnosis and Treatment
A2	Physically Handicapped Children's Program	Services provided under this program receive special funding through Title 8 of the Social Security Act or the CHAMPUS Program for the Handicapped.

A3	Special Federal Funding	This code has been designed for uniform use by state uniform billing committees.
A4	Family Planning	This code has been designed for uniform use by state uniform billing committees.
A5	Disability	This code has been designed for uniform use by state uniform billing committees.
A6	PPV/Medicare	This code identifies that pneumococcal pneumonia 100% Payment vaccine (PPV) services given should be reimbursed under a special Medicare program provision.
A7	Induced Abortion Danger to Life	Abortion was performed to avoid danger to woman's life.
A8	Induced Abortion Victim of Rape/Incest	Self-explanatory
A9	Second Opinion Surgery	Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.

PRO APPROVAL INDICATOR SERVICES

C1	Approved as Billed	The services provided for this billing period have been reviewed by the PRO/UR or intermediary, as appropriate, and are fully approved including any day or cost outlier.
C3	Partial Approval	The services provided for this billing period have been reviewed by the PRO/UR or intermediary, as appropriate, and some portion has been denied (days or services).
C4	Admission Services Denied	This should only be used to indicate that all of services were denied by the PRO/UR.
C5	Postpayment Review Applicable	This should be used to indicate that the PRO/UR review will take place after payment.
C6	Admission Preauthorization	The PRO/UR authorized this admission/service but has not reviewed the services provided.
C7	Extended Authorization	The PRO has authorized these services for an extended length of time but has not reviewed the services provided.

FL 31 **Untitled**

Not required.

FL 32-35 a-b **Occurrence Codes and Dates**

These fields apply to both inpatient and outpatient billing where applicable.

Enter the appropriate codes and dates from the table below. A maximum of 10 occurrence codes can be utilized. Fields 32a-35a must be completed before field 32b-35b can be utilized. If all the occurrence code fields 32a & b - 35a & b are filled, then 36a & b may be used to capture additional occurrence codes. When FL 36 is used in this way the "through" date is left blank.

NOTE: All acute care hospital inpatient invoices will need a Code 42 - Date of Death/Discharge.

Code Structure:

ACCIDENT RELATED CODES

01	Auto Accident	Code indicating the date of an auto accident.
02	No Fault Insurance Involved - Including Auto Accident/Other	Code indicating the date of an accident including auto or other where state applicable no fault liability laws (i.e., legal basis for settlement without admission of proof of guilt.
03	Accident/Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability.
04	Accident/Employment Related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other Accident	Code indicating the date of an accident not described by the above codes.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

INSURANCE RELATED CODES
(Third Party Liability rejection reasons other than Medicare)

24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the hospital from any insurer.
25	Date Benefits Terminated by Primary Payer	Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.

NOTE: The above two codes replace TPL rejection codes 61 – 69.

NOTE:	Codes 27-30	Should not be used by hospitals unless they own these facilities
27	Date Home Health Plan Established or Last Reviewed	Code indicating the date a home health plan or treatment was established or reviewed.

SERVICE RELATED CODES

42	Date of Discharge	Enter the date of death/discharge

FL 36a &b **Occurrence Span Codes and Dates**

Enter the code and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two numeric digits and dates are shown as MMDDYY.

When form locators 36a & b are utilized then Form Locators 34 & 35 may also be utilized to contain the "From" and "Through" dates of an additional occurrence span code. In this case, the code in Form Locator 34 will be the occurrence span code and the occurrence span "From" date will be in the date field. Form Locator 35 would contain the same occurrence span as the code in Form Locator 34 and the occurrence span "Through" date will be in the date field.

Code Structure:

	71	Prior Stay Dates	The from/through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
*	74	Non-Covered Level of Care	The from/through dates of a period at a non-covered level of care in an otherwise covered stay.

**	75	SNF Level of Care	The from/through dates of a period of SNF level of care during an inpatient hospital stay. Code should be used only when the PSRO/PRO has approved the patient remaining in the hospital because of the nonavailability of an SNF bed. Code is not applicable to swing-bed cases. For hospitals under prospective payment, this code is needed in day outlier cases only.
	80	Patient Resource Amount	Enter the from/through dates indicated as the "begin" and "expiration" dates on the DHMH 4233, Notice of Eligibility letter. Indicate patient resources in FL 39-41 a,b,c, or d. Use code D3 and indicate the resource shown on the DHMH 4233, Notice of Eligibility letter.

* **NOTE:** Code 74 is to be used by those Chronic, Psych, Rehab, and RTC providers for LOA days non-covered by the Medicaid Program. If Form Locator (FL) 36a or b equal 74, then the from and through dates must equal those days noncovered. FL's 6, 7, 8 and 36 a or b must equal the total sum of days billed in FL 46. (FL 6 must include dates for both covered and noncovered days).

** **NOTE:** Code 75 = Administrative Days. Form DHMH 1288 is required.

FL 37 **Internal Control Number (ICN)/Document Control Number (DCN)**

Not Required. (Future)

FL 38 **Untitled**

Responsible party name and address. Not required.

FL 39-41 a-b Value Codes and Amounts

Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for processing of the claim. The codes are two digits either number or alpha-numeric, and each value allows up to nine numeric digits (0,000,000.00). Negative amounts are never shown. Value codes must be entered in numerical sequence starting with code 01. Fields 39a through 41a must be completed before the b fields, etc.

Code Structure:

06	Medicare Blood Deductible	Total cash blood deductible, if appropriate. Enter the Part A blood deductible amount.

08	Medicare Life Time Reserve Amount in the First Calendar Year	Medicare life time reserve amount charged in the year of admission.
09	Medicare Coinsurance Amount in the First Calendar Year	Medicare coinsurance amounts charged in the year of admission.
10	Lifetime Reserve Amount in the Second Calendar Year	Medicare lifetime reserve coinsurance amount charged in the year of discharge where a bill spans two calendar years.
11	Coinsurance Amount in the Second Calendar Year	Medicare coinsurance amount charged in the year of discharge where the inpatient bill spans two calendar years.
23	Recurring Monthly Income	For inpatient only, enter the amount of the patient's available income as indicated on the DHMH 4233, Notice of Eligibility letter.
31	Patient Liability Amount	The amount approved to charge the beneficiary for noncovered accommodations, diagnostic procedures, or treatments.
37	Pints of Blood Furnished	Total number of pints of whole blood or units of packed red cells furnished to the patient.
38	Blood Deductible Pints	The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.
39	Pints of Blood Replaced	The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient.
46	Number of Grace Days	Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care. (For Medicare see HIM 10, Section 405).
A1	Deductible PayerA	The amount assumed by the hospital to be applied to the patient's deductible amount involving the indicated payer. (Medicare inpatient deductible)

B1	Deductible Payer B	The amount assumed by the hospital to be applied to the patient deductible amount involving the indicated payer.
C1	Deductible Payer C	The amount assumed by the hospital to be applied to the patient deductible involving the indicated payer.
A2	Coinsurance Payer A	The amount assumed by the hospital to be applied toward the patient's coinsurance amount involving the indicated payer.
B2	Coinsurance Payer B	The amount assumed by the hospital to be applied toward the patient's coinsurance amount involving the indicated payer.
C2	Coinsurance Payer C	The amount assumed by the hospital to be applied toward the patient's coinsurance amount involving the indicated payer.
D3	Estimated Patient Responsibility	For inpatient only. Enter the amount of the patient resource as indicated on the DHMH 4233, Notice of Eligibility letter.

FL 42 **Revenue Codes**

Enter the appropriate four digit numeric revenue code from the matrix enclosed to identify specific accommodation and/or ancillary charges. The appropriate four digit numeric revenue code must be entered to explain each charge in FL 47.

There is no fixed "total" line in the charge area. Revenue code "0001" is entered instead in FL 42. Thus, the adjacent charge entry in FL 47 will be the sum of charges billed.

To assist in bill review, revenue codes should be listed in ascending numeric sequence with the exception of "0001" which should always be last. Accommodations must be entered first on the bill and in revenue code sequence. Revenue codes must not be repeated on the same bill.

The new revenue code to be used when billing for administrative days is 0169.

NOTE: Detail beyond 0 level code in fourth digit field is not required unless specified.

FL 43 **Revenue Descriptions**

Not required. Enter a narrative description or standard abbreviation for each revenue code shown in FL 42. Descriptions or abbreviations will correspond to the revenue codes shown in the matrix.

FL 44 **HCPCS/RATES**

The appropriate HCPCS codes associated with the surgical revenue codes listed below need to be used when billing for outpatient services.

Revenue Codes: 0360, 0361, 0490, 0499, 0750, 0759, 0790, 0799.

FL 45 **Service Date**

Future. Will be required when billing for outpatient services.

FL 46 **Units of Service**

Enter the number of days or units of service on the line adjacent to the revenue code where appropriate. There must be a unit of service for every revenue code except 0001.

Up to five numeric digits (99999) may be entered.

Units of service include the total of both covered and non-covered services when you are billing total covered and non-covered charges in FL 47.

NOTE: Units of service must be the sum of the covered and non-covered days when billing for non-covered days such as hospital day limits of uncompensated care.

FL 47 **Total Charges**

Sum the total covered and non-covered charges for the billing period by revenue code (FL 42) and enter them on the adjacent line in FL 47. Inpatient line items allow up to nine numeric digits (0,000,000.00). Outpatient line items allow up to seven numeric digits (00,000.00), up to a maximum charge amount of $50,000.00.

The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. Sum column 47 on the adjacent line. The 0001 total allows up to nine numeric digits (0,000,000.00).

NOTE A: Your facility may opt to bill only covered charges, except for hospitals billing for hospital day limit uncompensated care.

NOTE B: Newborn charges must be billed separately under the newborn's Medical Assistance Number.

FL 48 **Non-Covered Charges**

Enter charges that are non-covered under the Medical Assistance program. Inpatient line items allow up to nine numeric digits (0,000,000.00). Outpatient line items allow up to seven numeric digits (00,000.00) up to a maximum charge amount of $50,000.00.

The charge entered in FL 48 is the "0001" total charge which represents the grand total of all charges billed. Sum column 48 on the adjacent line. The 0001 total allows up to nine numeric digits (0,000,000.00).

All charges in FL 48 will be subtracted from total charges in FL 47.

NOTE: If your facility has opted to bill only covered charges in FL 47 then this column will be blank. This column should not be blank for hospitals billing for hospital day limit uncompensated care.

FL 49 **Untitled**

Not required.

FL 50 a,b,c **Payer Identification**

First line, 50A is a Primary Payer Identification. Second line, 50B is Secondary Payer Identification. Third line, 50C is Tertiary Payer Identification. Multiple payers should be listed in priority sequence according to the priority the provider expects to receive payment from these payers.

NOTE: If other payers listed, then Medicaid should be the last entry in this field.

FL 51 a,b,c **Medical Assistance Provider Number**

Enter the 9 digit provider number assigned by the Medical Assistance Program.

NOTE: If other provider numbers listed, then the Medical Assistance provider number should be the last entry in this field.

FL 52 a,b,c **Release of Information Certification Indicator**

Not required.

FL 53 a,b,c **Assignment of Benefits Certification Indicator**

Not required.

FL 54 a,b,c **Prior Payments - Payer and Patients**

The amount the hospital has received toward payment of this bill prior to the billing date to the indicated payer.

Enter the amount paid by the primary payer and/or the amount paid by the patient insured.

These amounts should be entered on lines a,b,or c according to payer in FL 50 or in the fourth line (P) is paid by patient.

FL 55 a,b,c **Estimated Amount Due**

Not required.

FL 56 **Untitled**

Not required.

FL 57 **Untitled**

Not required.

FL 58 a,b,c **Insured's Name**

Not required.

FL 59 a,b,c **Patient Relationship to Insured**

Not required.

FL 60 **Certificate/SSN/HIC/ID Number**

Enter the Medical Assistance number of the insured as it appears on the Medical Assistance card. If billing for a newborn, you must use the newborn's Medical Assistance number.

If there are other insurance numbers shown, such as Medicare, then the Medicaid identification number should appear last in the field.

REMINDER: Providers may verify a patient's current Medical Assistance eligibility by calling the Eligibility Verification Services (EVS) line:

Baltimore Metropolitan Area:	(410) 333-3020
Toll-Free Long Distance:	1-800-492-2134

If the patient does not have his Medicaid identification card, a provider may call (410) 767-5503, or 1-800-445-1159, identify themselves by provider number, give the patient's full name, address, social security number, and date of birth and obtain the Medical Assistance number.

Providers will also be able to check eligibility through the HIPAA compliant transaction 270/271 once the provider has tested and been approved.

FL 61 **Insured's Group Name**

Not required.

FL 62 **Insurance Group Number**

Not required.

FL 63 **Treatment Authorization Code**

Enter the Document Number from the upper right corner of the DHMH 3808 "Admission and Length of Stay Certification". This is required for inpatient billing only and only when the 3808 is required. (NOTE: 8-digit number. If DHMH 3808 number is 7 digits, front-fill with a zero.)

FL 64 a,b,c **Employment Status Code**

Not required.

FL 65 **Employer Name**

Not required.

FL 66 **Employer Location**

Not required

FL 67 **Principal Diagnosis Code**

Enter the full ICD-9-CM code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

The ICD-9-CM codes will be used for inpatient and outpatient services.

NOTE A: The principal diagnosis code will include the use of "V" codes. The "E" codes are not acceptable for principal diagnosis.

Always code to the most specific level possible, but do not enter any decimal points when recording codes on the UB-92.

NOTE B: When billing for newborn, must use newborn diagnosis codes.

FL's 68-75 **Other Diagnosis Codes**

Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment or the length of stay.

Enter the appropriate ICD-9-CM diagnosis code (co-morbidity) in FL 68 which determines the DRG selected.

Completion of FL 69 through 75 are currently optional as our data processing system will accept one principal and three co-existing diagnoses.

NOTE: For the 3808, the principal and 1st secondary diagnosis should be what determines the DRG. When billing, UB92 diagnosis codes must sequentially match the 3808.

FL 76 **Admitting Diagnosis**

Not required.

FL 77 **External Cause of Injury Code (E-Code)**

Not required.

FL 78 **Untitled**

Not required

FL 79 **Procedure Coding Method Used**

Optional.

5 = HCPCS (HCFA Common Procedure Coding System)
9 = ICD-9-CM

FL 80 **Principal Procedure Code and Date**

Enter the principal procedure code, if any, performed during the billing period as shown in the patient's medical record. In determining which of the several procedures is the principal, the following criteria should be applied in sequence.

a. The principal procedure is one which was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes or was necessary to take care of a complication; or

b. The principal procedure is that procedure most related to the principal diagnosis.

This code structure must be ICD-9-CM for inpatient and outpatient services.

Whenever a procedure is provided a date must be supplied - format is "MMDDYY".

FL 81 a-e **Other Procedure Codes and Dates**

Enter the full ICD-9-CM codes and dates identifying the procedures, other than the principal procedures, performed during the billing period covered by this bill.

This code structure must be followed when billing for inpatient or outpatient services.

Whenever a procedure is provided, a date must be supplied, format is "MMDDYY".

Completion of FL81 a-e are optional as our data processing system will only accept the principal code and date and two additional procedure codes and dates.

NOTE: Procedure codes must match 3808.

FL 82 **Attending Physician Identification Number**

Inpatient: Enter the number assigned by Medicaid for the physician attending an inpatient. This is the physician primarily responsible for the care of the patient from the beginning of this hospitalization.

Outpatient: Enter the number assigned by Medicaid for the physician referring the patient to the hospital. When a patient is not referred or has no private physician, the attending physician is the staff member to whom the patient is assigned.

Enter the 9 digit Medical Assistance provider number of the patient's attending physician. If the attending physician is not a Medical Assistance provider, enter "000005100". If the attending physician is a member of the house staff and is not a Medical Assistance provider, enter "888885000". If the attending physician has a Medical Assistance provider number but it is not known/available, enter "999995700".

FL 83 **Other Physician Identification Number**

Inpatient: Enter the number assigned by Medicaid for the operating physician who performed the principal procedure, if any.

Outpatient: Enter the number assigned by Medicaid for the operating physician who performed the principal procedure, if any.

If the operating/referring physician is not a Medial Assistance provider, enter “000005100”. If the operating/attending physician is a member of the house staff and is not a Medical Assistance provider, enter “888885000”. If the operating/attending physician has a Medical Assistance provider number but it is not known/available, enter “999995700”. If surgical services have not been performed or the patient was not referred, do not complete this space.

*Hospice Care: Enter the 9 digit Hospice Physician Services Number assigned by Medicaid to the Hospice Care Provider submitting the UB-92

FL 84 **Remarks**

Not required

FL 85 **Provider Representative Signature**

Not required.

FL 86 **Date Bill Submitted**

Complete this field with the 6 digit date billed.

ATTACHMENT A

Department of Health and Mental Hygiene
Maryland and DC Hospitals Subject To Day Limits

MARYLAND HOSPITALS

Provider Number	*Acute Hospital*
0002054	Anne Arundel General Hospital
7561750	Atlantic General Hospital
0001759	Bon Secours Hospital
0002151	Calvert Memorial Hospital
0004251	Carroll County General Hospital
0003352	Civista Medical Center
0688851	Doctors Hospital
0002259	Dorchester General Hospital
0002852	Edward W. McCready Memorial Hospital
0967751	Fort Washington Medical Center
0000451	Franklin Square Hospital
0002356	Frederick Memorial Hospital
0002453	Garrett County Memorial Hospital
0007153	Good Samaritan Hospital
0004553	Greater Baltimore Medical Center
0001457	Harbor Hospital Center
0002551	Harford Memorial Hospital
0004359	Holy Cross Hospital
1044044	Howard County General Hospital
0935751	James L. Kernan Hospital
3414752	Johns Hopkins Bayview Medical Center
0000655	Johns Hopkins Hospital
0002658	Kent and Queen Annes General Hospital
2876159	Laurel Regional Hospital
0000850	Maryland General Hospital
0003051	Memorial Hospital at Easton
7548257	Memorial Hospital at Easton
0000957	Mercy Hospital
0002950	MHMC of Cumberland
0003158	Montgomery General Hospital
0004456	North Arundel Hospital
3432751	Northwest Hospital Center
0003255	Peninsula Regional Medical
0003450	Prince Georges Hospital
0003557	Sacred Heart Hospital
4028244	Shady Grove Adventist Hospital
0001350	Sinai Hospital
4558057	Southern Maryland Hospital
0001155	St. Agnes Hospital
0001252	St. Josephs Hospital
0003654	St. Mary's Hospital
0003751	Suburban Hospital
0003859	Union Hospital of Cecil County
0001554	Union Memorial Hospital
3409252	University of Maryland Medical Center
0004758	Upper Chesapeake Medical Center
4028252	Washington Adventist Hospital
0003956	Washington County Hospital

Provider Number	*Acute Rehab*
2022052	MHMC Cumberland
2257858	Laurel Regional Hospital
2411024	Johns Hopkins Hospital
2825155	James L. Kernan Hospital
4206657	Maryland General Hospital
4740556	Sinai Hospital
0008150	Good Samaritan Hospital
0809659	Union Memorial Hospital
1138456	Washington County Rehabilitation Hospital

WASHINGTON, DC

Provider Number	*Acute Hospital*
6624014	George Washington University Hospital
9500456	Georgetown University Hospital
9733027	Greater Southeast Community
0052051	Howard University Hospital
0051454	Providence Hospital
0051551	Sibley Memorial Hospital
0050458	Washington Hospital Center

Note: Provider numbers are missing the two-digit location number.